Semi-Annual Report to the

Joint Legislative Oversight Committee

on Mental Health, Developmental Disabilities and Substance Abuse Services

on

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2009-10: Fall Report

Session Law 2006-142

House Bill 2077

Section 2.(a)(c)

October 1, 2009

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

Legislation in 2006 requires the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to report to the Legislative Oversight Committee every six months on progress made in seven statewide performance domains. This report is the fifth in a series of reports, with each report building upon previous reports. The following are highlights from each of the domains herein.

Highlights

Domain 1: Access to Services – (1) The number of persons enrolled by local management entities (LMEs) across the state increased in the past year in every age-disability group except children/adolescents with mental health disorders and a slight decrease seen for adults and children/adolescents with developmental disabilities. Overall increases in the number of persons served can be attributed to both improvements in LME data submission and an increase in admissions. (2) Almost all persons seeking emergent care are seen by a provider promptly after requesting services; 83% of persons seeking urgent care are seen within 48 hours of requesting services; and three-fourths of persons seeking routine care (non-urgent) are seen within fourteen calendar days.

Domain 2: Individualized Planning and Supports – (1) The majority of families of consumers with developmental disabilities who live at home report choosing the provider agency and support workers for their family member at a much higher rate than reports of families in other states. In addition, much like reports from families in other states, North Carolina families of consumers with developmental disabilities report significant involvement in the planning of services for their family member. (2) The vast majority of consumers with mental health and substance abuse disorders report choosing the services they received as well as their treatment goals. However, fewer adolescents report being involved in choosing their provider or services than other age groups and fewer adults report deciding their treatment goals compared to other age groups.

Domain 3: Promotion of Best Practices – (1) New mobile crisis management teams and NC START teams have begun to serve MH/DD/SA consumers in crisis in their communities, reducing the need for psychiatric hospitalization. The number of evidence-based mental health services has been increasing over the past two fiscal years. The number in evidence-based substance abuse services steadily climbed, but fell in the fourth quarter of SFY 2008-09, possibly due to the lag time needed for claims to be reported. (2) Admissions to the state alcohol and drug abuse treatment centers have increased considerably in recent years, while there has been a drop in admissions to state psychiatric hospitals in the past two years, due in part to policies to delay admissions when hospitals are over capacity. (3) Readmissions to state psychiatric hospitals continue to remain lower for children than for adults.

Domain 4: Consumer-Friendly Outcomes – (1) While most consumers with developmental disabilities report choosing where they live and work, an even larger percentage report choosing the staff who assist them at home and work. (2) Mental health and substance abuse consumers continue to show meaningful improvements in various aspects of their lives after three months of service.

Domain 5: Quality Management Systems – (1) Results of a recent survey seeking input from LMEs and provider agencies involved in developing a statewide monitoring tool and process showed that 94% of LMEs and providers were satisfied with the number of cases reviewed and close to three-fourths found the tool to rate providers appropriate. (2) A new web-based incident reporting system, the NC Incident Response Information System (NC-IRIS) is being implemented to replace the current paper-based system.

Domain 6: System Efficiency and Effectiveness – (1) LMEs' timely and accurate submission of data to the Division has improved by six percentage points and submission of reports has improved by seven

percentage points during the last state fiscal year. (2) Thirteen LMEs received single stream funding in SFY 2008-09.[1] Half reported the expected volume of services for the fiscal year as "shadow claims."

Domain 7: Prevention and Early Intervention – The North Carolina State Epidemiological Workgroup, comprised of staff from multiple state agencies, published a Substance Abuse Data Inventory, as a part of the North Carolina Strategic Prevention Framework-State Incentive Grant. This comprehensive report describes data repositories, data systems, and data sources that contain indicators of substance abuse consumption patterns and consequences in North Carolina for use by local and state program planners and evaluators.

[1] Single stream funding is a mechanism that provides LMEs with flexibility in the use of their funds. The LMEs receive their state allocations in monthly payments and report client and service specific information through the state billing system ("as shadow claims") in lieu of fee-for-service reimbursement.

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Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2009-10: Fall Report

Introduction

The *Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report* is presented in response to Session Law 2006-142, Section 2.(a)(c) and builds on the measures reported in previous semi-annual reports (See Appendix A).

Measuring Statewide System Performance

The domains of performance written into legislation reflect the national consensus on goals that all states should be working toward, specifically to provide support for individuals with disabilities to be able to live productive and personally fulfilling lives in communities of their choice. The Division has chosen measures that can be used to evaluate the implementation of system improvement efforts and the impact on system performance and consumers' lives. The measures relate to:

- The strategic objectives of the *State Strategic Plan 2007-2010*.
- SAMHSA National Outcome Measures (NOMS) (See Appendix B for details).
- Areas of quality recommended in the CMS Quality Framework (See Appendix C for details).

Where applicable, the Division is also aligning measures of statewide performance with local performance indicators published in the quarterly *Community Systems Progress Report*, so that each LME can evaluate its own progress in relation to the state as a whole.

For each performance area, the following sections include:

- A description of the domain.
- A statement of its relevance to system improvement efforts and importance in a high-quality system.
- One or more measures of performance for that domain, each of which includes:
    - A description of the indicator(s) used for the measure.
    - The most current data available for the measure.
    - Division expectations about future trends and plans for addressing problem areas.

Appendix D provides information on the data sources for the information included in each domain.

Domain 1: Access to Services

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse services needs who request help. Timely access is

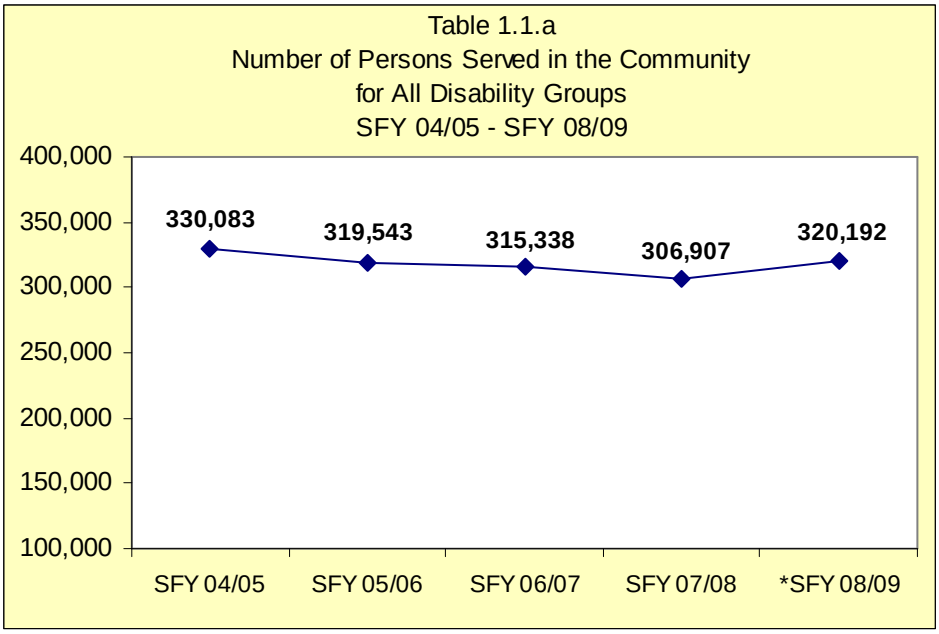
essential for helping people get care during times of their greatest vulnerability and/or openness to assistance. It is the first step in engaging people in care long enough to improve or restore personal control over their lives, to prevent future crises and to minimize the impact of disabilities on their lives.

Measure 1.1: Persons Receiving Community Services

Measure 1.1 contains information on the number of persons that the state's mental health, developmental disabilities and substance abuse system has served over the past five state fiscal years, according to the LMEs' data on enrolled consumers. In the following three tables, the number of persons served is determined from data submitted to the Division's Client Data Warehouse (CDW) by the LMEs.[2]

Based on data the LMEs submit, Table 1.1.a shows that the number of persons who have been served in the community over the past five state fiscal years experienced a steady decrease from SFY 2004-05 to SFY 2007-08, but has increased four percent in the last fiscal year. Roughly two-thirds of the LMEs served more consumers in SFY 2008-09 than in the previous fiscal year. The decrease during the earlier years was, at least in part, due to changes in data submission and data sharing policies. In addition, in SFY 2005-06 the Division began requiring LMEs to complete a discharge record on consumers who had not received any service for sixty days (or 365 days for adult mental health consumers in recovery) in order to improve the accuracy of data on persons being *actively* served. As expected, this resulted in the closing of *inactive* records, which is reflected in the decrease through SFY 2007-08. The increase in SFY 2008-09 reflects continued improvement in data quality, as LMEs have resolved issues around data submission and the Department has begun providing information to LMEs on consumers served by directly-enrolled Medicaid providers.

Table 1.1.a
Number of Persons Served in the Community
for All Disability Groups
SFY 04/05 - SFY 08/09



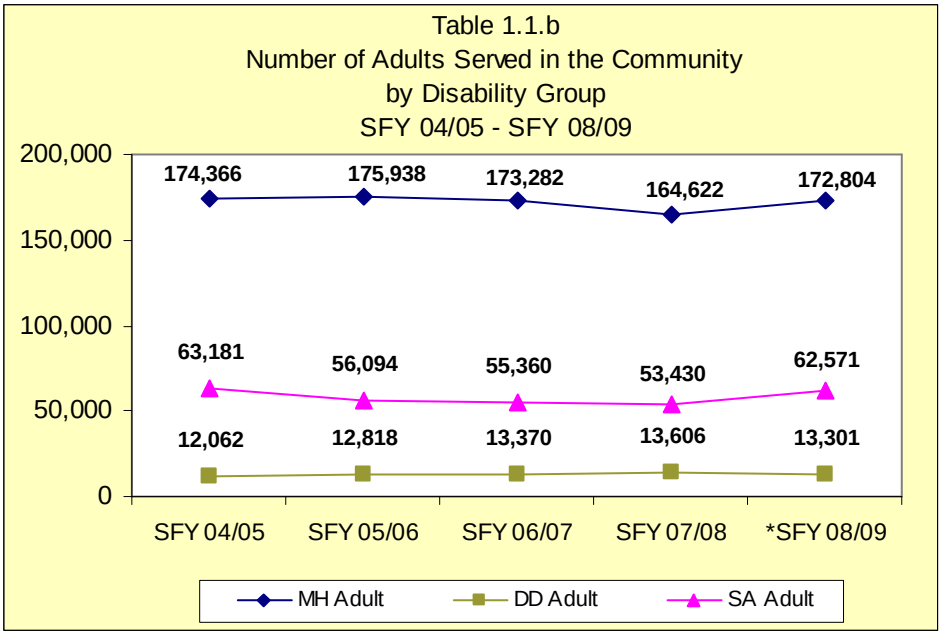
SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2004 - June 30, 2009.

[2] SFY 2008-09 numbers are based on preliminary data. Official numbers for total persons served in SFY 2008-2009 will be available in November 2009 and will be updated in future reports. The numbers for SFY 2007-2008 have been updated since the Fall 2008 Report.

Table 1.1.b. shows differing patterns by disability for the number of adults who have been served in the community over the past five state fiscal years.

- **Adults with a primary mental health diagnosis:** The number of adults served in the community over the past five years has decreased slightly by 1%.
- **Adults with a primary developmental disability diagnosis:** The number of adults served in the community over the past five years has increased by 10%.
- **Adults with a primary substance abuse diagnosis:** The number of adults served in the community over the past five years has decreased slightly by 1%.

While there was a downward trend in treatment services to adults with substance abuse problems in SFY 2004-05 through SFY 2007-08, there was a 17% increase in persons served in the past fiscal year. A very similar trend was occurring with adult mental health consumers, which saw a five percent increase in persons served in the past year. While services to adults with developmental disabilities has experienced a ten percent increase over the past five fiscal years, in the three most recent years, the numbers of adults served has remained relatively stable.

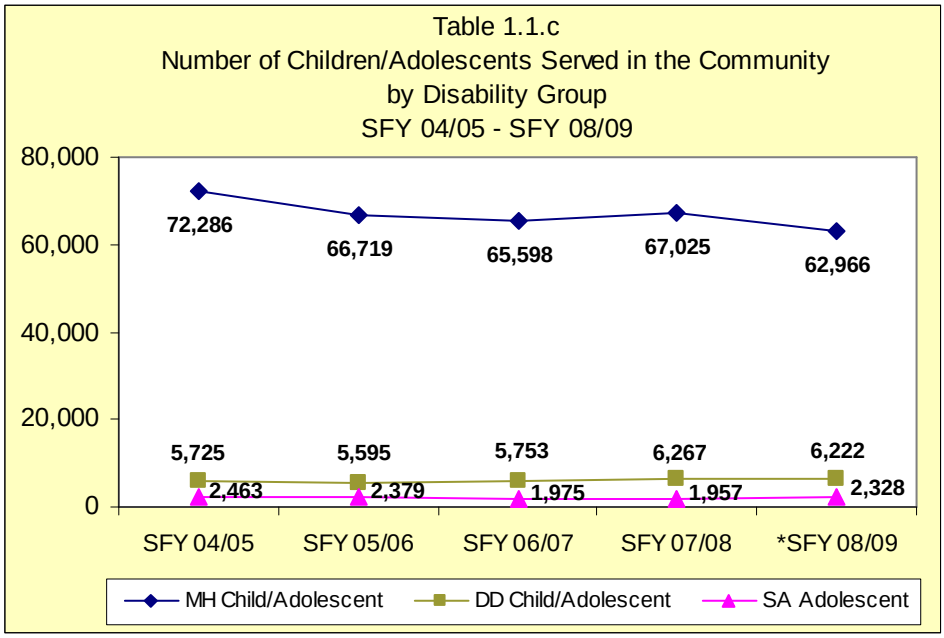


SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2004 - June 30, 2009.

Table 1.1.c, on the next page, shows the number of children and/or adolescents who received publicly-funded services in the community through the LMEs over the past five state fiscal years. Mental health and substance abuse were the two disabilities which experienced a decrease in the number of children and/or adolescents served in the community over the past five years. This decrease in the past state fiscal year reflects the success of the Department's activities to control the inappropriate overuse of community support services. Children and/or adolescents with developmental disabilities saw a slight increase in numbers of persons served.

- **Children/Adolescents with a primary mental health diagnosis:** The number of children and adolescents served in the community over the past five years has decreased by 13%.
- **Children/Adolescents with a primary developmental disability diagnosis:** The number of children and adolescents served in the community over the past five years has increased by 9%.

- **Children/Adolescents with a primary substance abuse diagnosis:** The number of adolescents served in the community over the past five years has decreased by 6%.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2004 - June 30, 2009.

The Division continues to work closely with LMEs and providers to develop and implement strategies to better identify and engage children and adolescents with substance abuse problems.

Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure[3] that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that might otherwise result in greater trauma to the individual and more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

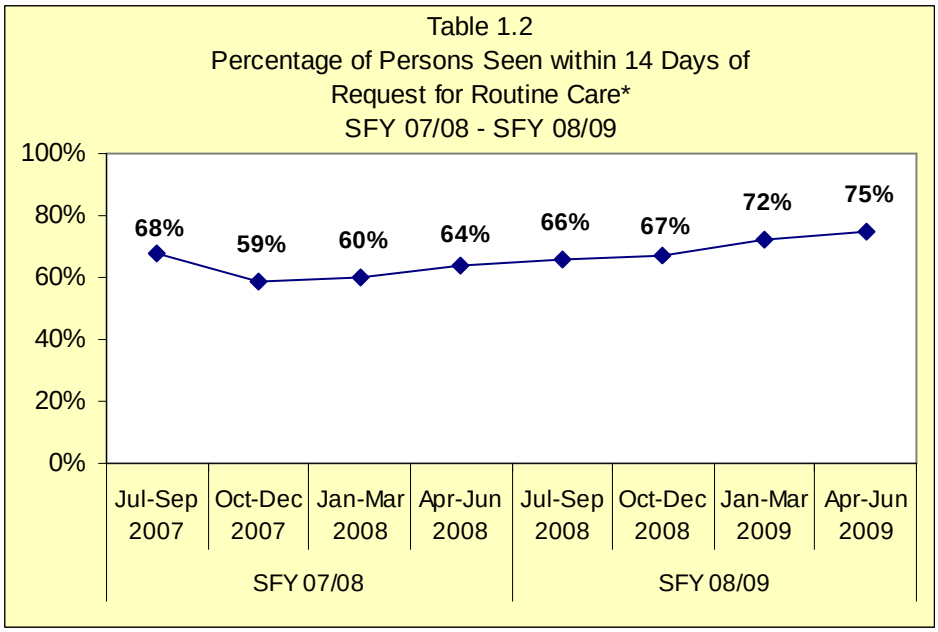
Individuals who request care during crisis situations are usually seen very quickly. In the last quarter of SFY 2008-09:

- 97.2% of those requesting care in emergency situations were seen within two hours.
- 82.7% of those requesting care in urgent situations were seen within 48 hours.

In the last quarter of SFY 2008-09, the percent of persons requesting routine (non-urgent) services who were *offered an appointment* within 14 calendar days was 92%. However, not all individuals keep those appointments (only 75% of consumers were seen, as shown in Table 1.2 on the next page). Follow-up by the LME or provider is often necessary to ensure that individuals keep or reschedule appointments.

[3] Health Plan Employer Data and Information Set (HEDIS©) measures.

Looking over time, the percentage of all consumers seeking routine care over the past two state fiscal years who were *actually seen* by a provider within the required timeframe of requesting services has steadily increased since the low of 59% reported in the second quarter of SFY 2007-08 to the high of 75% reported in the last quarter of SFY 2008-09.



SOURCE: Data from LME screening, triage, and referral logs submitted to the NC Division of MH/DD/SAS, published in Quarterly Performance Contract reports.
*NOTE: Prior to January 2008, the required timeframe was 7 calendar days. Beginning January 2008, the required timeframe changed to 14 calendar days.

The Division will continue monitoring the LMEs' progress in this matter as part of the *DHHS-LME Performance Contract*. **As a result of this monitoring and efforts to stabilize the provider system, the Division expects performance on this measure to continue to improve gradually.**

Domain 2: Individualized Planning and Supports

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to individuals (and to their families when appropriate) are more likely to engage them in service and encourage them to take charge of their lives. In addition, services that address what is important for them produce improved life outcomes more efficiently and effectively.

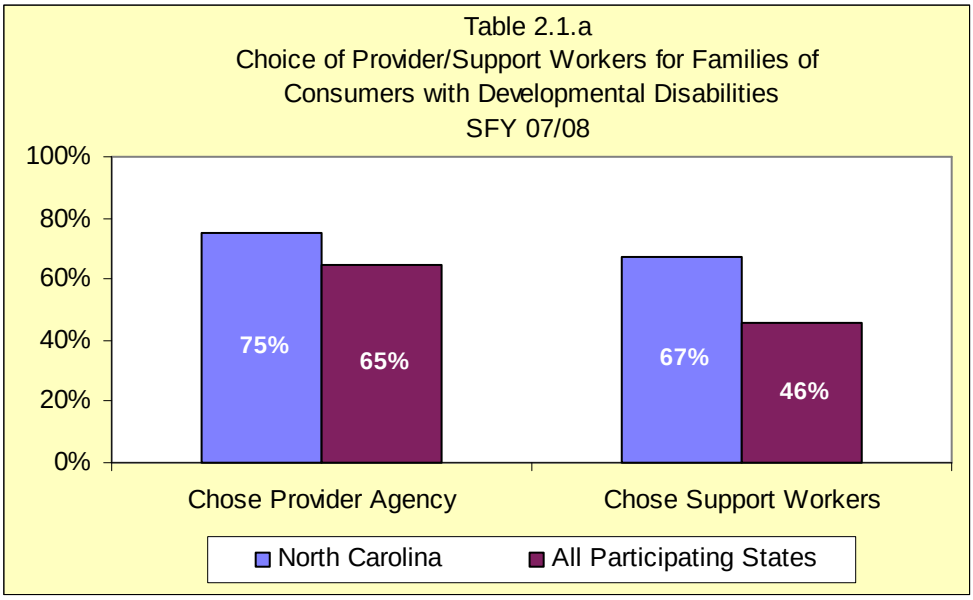
The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers, and receive assistance in obtaining and moving between services when necessary.

Measure 2.1: Consumer Choice of Providers

Offering choice is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help. In addition, having a voice in the service and staff person(s) that feel most supportive to an individual can mean the difference between

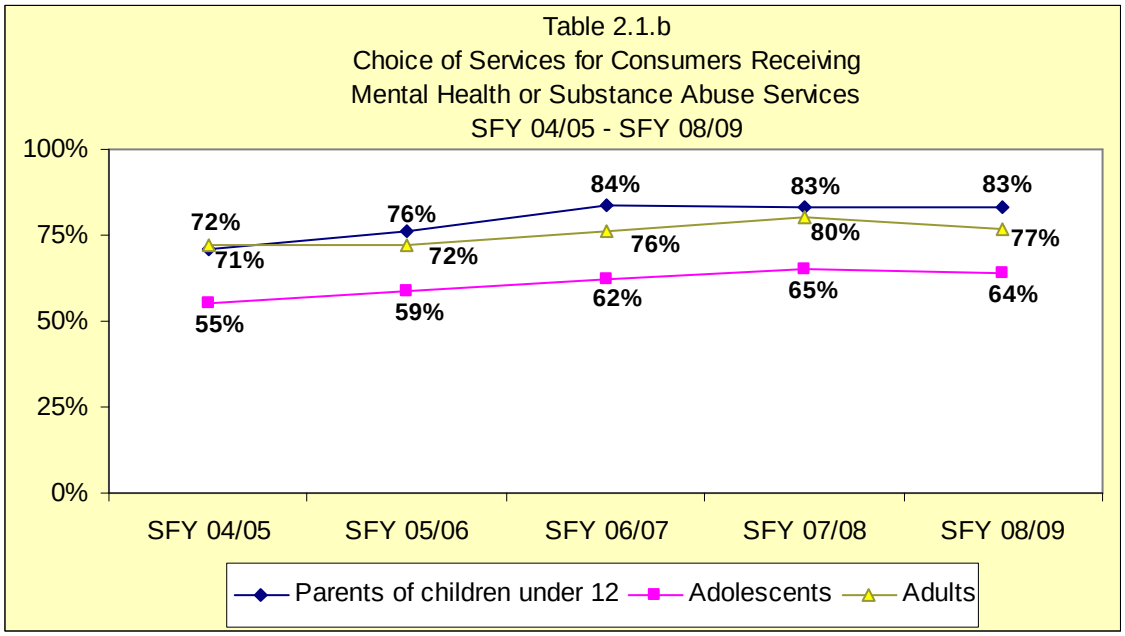
willing engagement in services or discontinuation of services before recovery or stability can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that can meet their individual scheduling and transportation requirements, address their individual needs effectively and encourage them in a way that feels personally comfortable and supportive. The tables on the following pages address the extent to which individuals report having a choice in who serves them and/or the services they receive.

Consumers with Developmental Disabilities (Table 2.1.a): In the most recent annual interviews with families of individuals with developmental disabilities who live *at home*, three-fourths of the families in North Carolina reported choosing the provider agency for their family member and two-thirds reported choosing the support workers for their family member (see Table 2.1.a below). For both of these measures, more families in North Carolina reported choosing a provider and support workers than was reported for all participating states. (See Appendix D for details on the National Core Indicators Project's Consumer Survey.)



SOURCE: National Core Indicators Project, Adult Family Survey. Project Year 2007-08.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.b): In the annual Division survey of persons with mental health or substance abuse disabilities, a large majority reported positive feedback regarding choosing the services they received. This positive trend has steadily increased over the past five years of the consumer survey among adolescents and parents of children under the age of twelve. Adults increased by nine percentage points from SFY 2004-05 to SFY 2007-08 but dropped by three percentage points in the past year. Adolescents were less likely than these two groups to report helping to choose their services, but have shown the greatest increase in choice of provider in the last five years (an increase of nine percentage points over five years). (See Appendix D for more information on the Mental Health Statistical Improvement Project Consumer Survey.)



SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

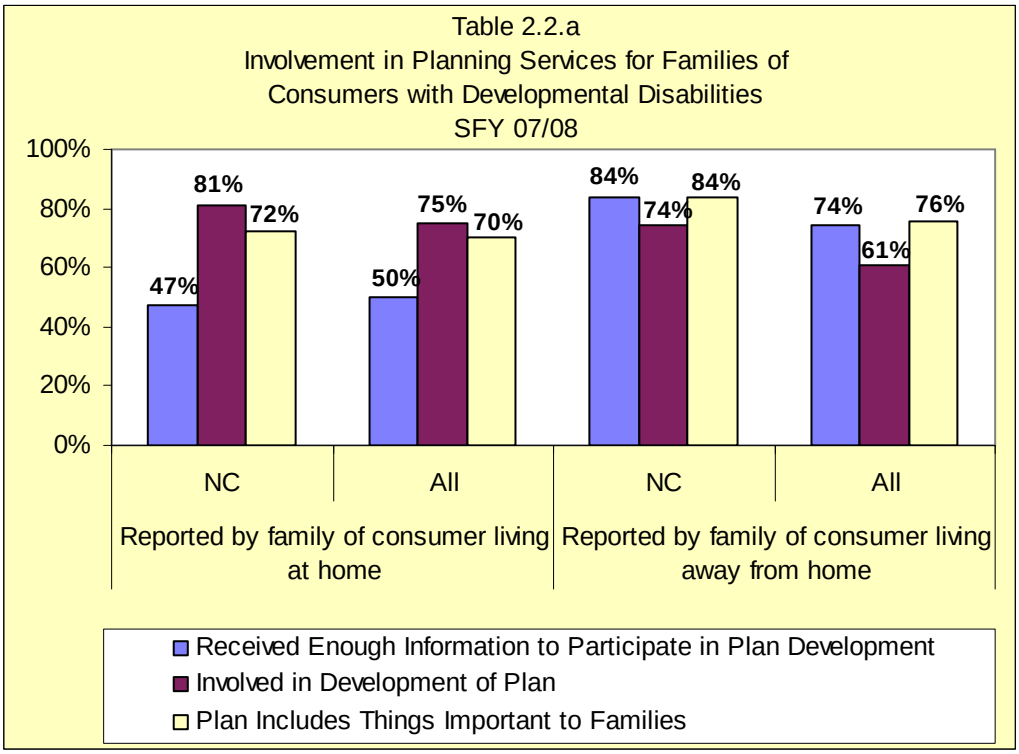
The growth of the community system over the past five years has offered consumers more opportunities to choose their services, which is reflected here. **The Division expects that changes due to the economic situation to have a slightly suppressing impact on performance in this measure in SFY 2009-10.**

Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. Having a voice in choosing personally meaningful goals is a critical step toward recovery and self-determination. The Division requires a PCP for most persons who receive enhanced benefit services,[4] and has implemented a standardized format and training to ensure statewide adoption of this practice. As the following tables show, a large majority of consumers and their family members are involved in the service planning and delivery process.

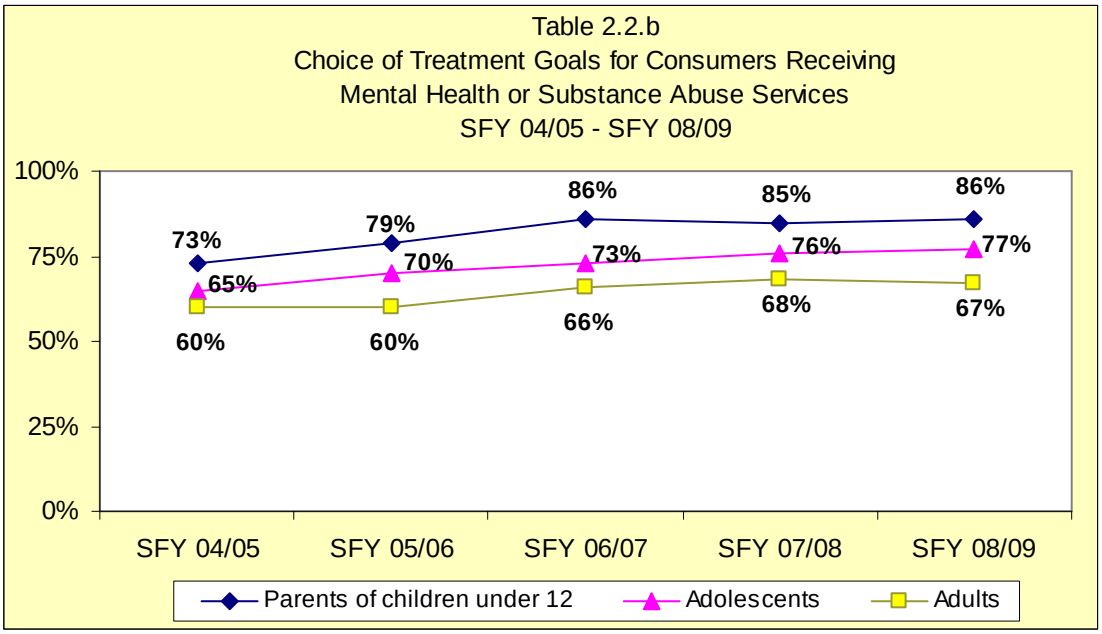
Consumers with Developmental Disabilities (Table 2.2.a): In three key areas related to service planning, the large majority of North Carolina families of consumers with developmental disabilities reported involvement in planning of services for their family members, as shown in Table 2.2.a on the next page. North Carolina families of consumers who live *at home* responded much like families in all participating states. North Carolina families of consumers who live *away from home* were much more likely to report involvement in planning compared to families in all states using this survey. (See Appendix D for more information on this survey.)

[4] "The enhanced benefit service definition package is for persons with complicated service needs." *State MH/DD/SAS Plan 2005*, p. 58.



SOURCE: National Core Indicators Project, Adult Family and Family Guardian Surveys. Project Year 2007-08.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.b): Every year in a consumer survey the Division asks mental health and substance abuse consumers about their choice of treatment goals. As Table 2.2.b on the next page shows, the vast majority of mental health and substance abuse consumers in the annual survey have consistently reported choosing or helping to choose their treatment goals across all groups reporting: parents of children under the age of 12, adolescents, and adults. Adults reported having less input into their treatment goals compared to parents of children under the age of 12 and adolescents, but like the other two age groups, have shown some improvement over the past five years.



SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

The state has made significant efforts to institute a recovery-oriented system of care that encourages consumer and family participation in service planning and delivery, as evidenced by the positive trends shown above. The continued growth and refinement of person-centered thinking will be important as LMEs, providers, consumers and families work to transition consumers out of over-utilization of community support and residential services to more focused and appropriate care. **The impact of these transitions on these measures will depend on how well LMEs and providers are able to indentify services that meet consumers' and families' expectations.**

Domain 3: Promotion of Best Practices

This domain refers to adopting and supporting proven models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown result in improved functioning of persons with disabilities, as well as promising practices that are recognized nationally. SAMHSA requires states to report on the availability of evidence-based practices as part of the National Outcome Measures in mental health and substance abuse prevention and treatment.

Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; offering incentives to providers who adopt those practices and providing oversight and technical assistance to ensure the quality of those services.

The North Carolina Practice Improvement Collaborative (NC PIC) provides guidance to the Division in determining the evidence-based practices that will be provided through our public system. With representatives of all three disabilities, the NC PIC meets quarterly to review and discuss practices that have been submitted for evaluation, examine issues that affect the readiness of the practice for adoption in our state, and to prioritize recommendations for the Division Director.

Measure 3.1: Persons Receiving Evidence-Based Practices

Community-based Crisis Services: An effective community-based service system starts with flexible, responsive crisis services that can come to the person in need and assist other responders on-site. This approach helps to prevent inappropriate, costly and unnecessary hospitalization or detention of persons undergoing a behavioral health crisis. In 2008 the General Assembly appropriated funds for these critical crisis services. General Session Law 2008-107 (HB2436) provided support for development of 30 community Mobile Crisis Management Teams and the NC START program to ensure timely, appropriate crisis response.

- Mobile Crisis Management Teams are comprised of professionals experienced in crisis management who respond around the clock to acute crisis situations. With access to a psychiatrist as needed, the team provides immediate triage and assessment of an individual's acute mental health, developmental disabilities and substance abuse conditions and effective intervention techniques to help stabilize the individual, while ensuring their safety as well as the safety of others. Effective prevention or de-escalation of a crisis situation by the mobile crisis team often helps the individual to remain in their current home, avoiding commitment to a psychiatric hospital or unnecessary criminal justice involvement.

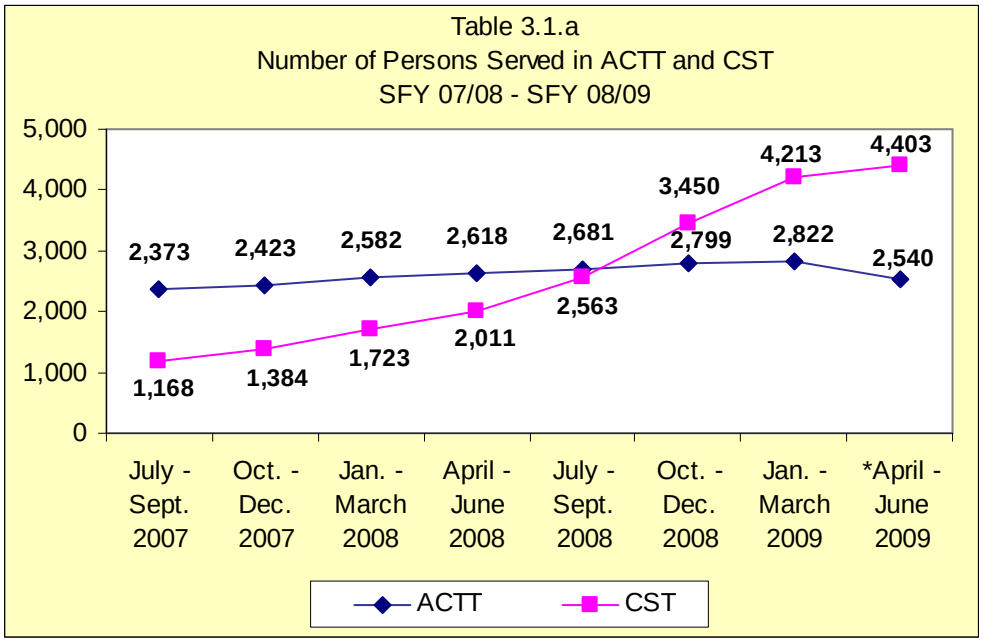
  Mobile Crisis Teams across the state responded to over 5000 crisis calls in the third quarter of SFY 2008-09 (January - March 2009). About one-quarter of the individuals in crisis were admitted to inpatient psychiatric or substance abuse treatment facilities. Only 61 were sent to jail or detention. The rest of those seen (over 3,800) were able to remain in community settings.

- NC START (North Carolina Systemic, Therapeutic Assessment, Respite and Treatment) is a community-based crisis prevention and intervention program for people with Intellectual/Developmental Disabilities (I/DD) who experience crises due to complex behavioral health issues. The six crisis teams (two per region) provide crisis prevention and intervention services, including round-the-clock crisis response, assessment and treatment. Teams also offer on-going consultation and cross-system preventative crisis planning for persons likely to need crisis services. The crisis prevention component of NC START also involves working with the existing systems of care to provide training, technical assistance, consultation and support to staff who work with individuals with I/DD and behavioral health issues.

  NC START teams also govern access to respite care for individuals with I/DD and behavioral health issues. There are two crisis respite beds (for stays up to 30 days) and two planned respite beds (for stays up to 72 hours) for each region. Respite home services include symptom and behavior monitoring, structured day activities, collaboration with the person's support team, and family support and education.

  During the fourth quarter (April-June 2009), the NC START teams responded to 160 requests for help with consumers in crisis, one-fifth of whom were admitted to crisis respite care. The teams also responded to an additional 101 requests for assistance or consultation in non-crisis situations,

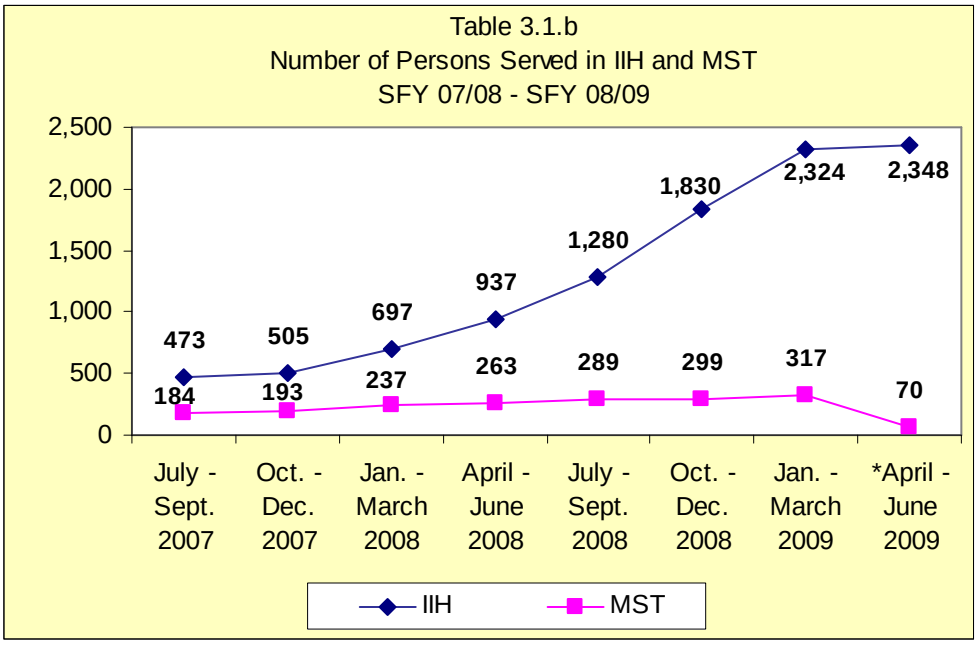
Consumers with Mental Health Disabilities: Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community support teams (CST) and assertive community treatment teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.a on the next page, the number of adults served in ACTT has been increasing steadily over the past two years (an increase of 7% since the first quarter of SFY 2007-08), while the number of adults served in CST has almost quadrupled during the past two state fiscal years.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2009.
*NOTE: Data reported in the fourth quarter of SFY 2008-09 is incomplete due to lag time for claims to be submitted and paid.

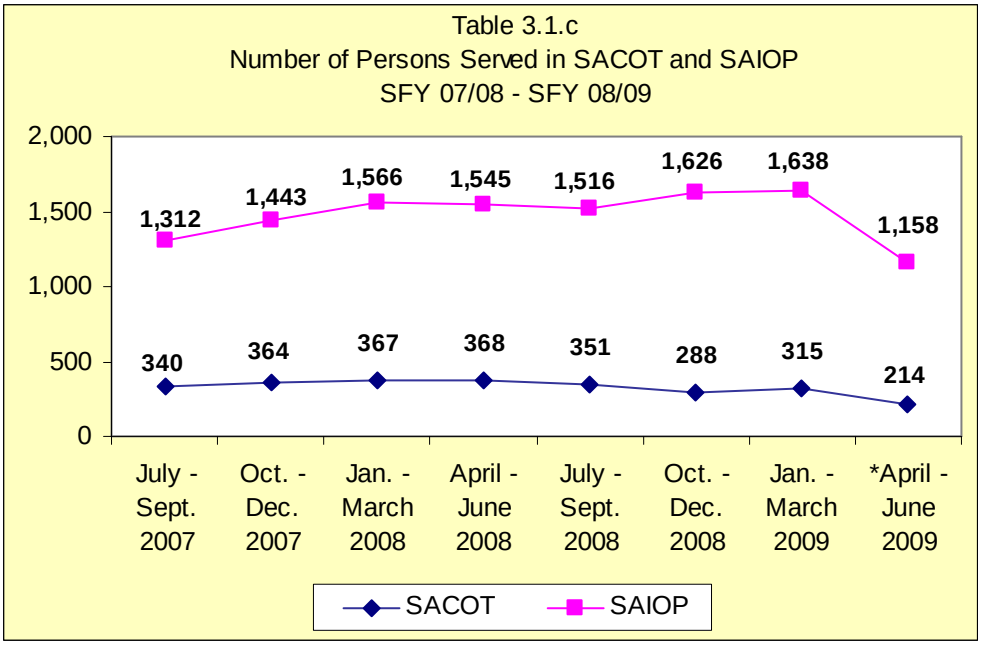
Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children placed in residential and inpatient care. Table 3.1.b on the next page shows that the number of youths served in IIH has increased 400% during the past two state fiscal years. The number of youths served in MST has doubled from 184 youth served in the first quarter of SFY 2007-08 to 317 youth served in the third quarter of SFY 2008-09.[5]

[5] The drop in the number of persons served in MST in the fourth quarter of SFY 2008-09 is likely due to a lag in provider submissions of service claims.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2009.
*NOTE: Data reported in the fourth quarter of SFY 2008-09 is incomplete due to lag time for claims to be submitted and paid.

Consumers with Substance Abuse Disabilities: Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The substance abuse intensive outpatient program (SAIOP) and comprehensive outpatient treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. SAIOP has seen a 25% increase in the number of persons served since the first quarter of SFY 2007-08 (see Table 3.1.c on the next page). [The drop in the fourth quarter of SFY 2008-09 is likely due to a lag in provider submissions of service claims.] SACOT had the highest number of persons served in the fourth quarter of 2007-08 with 368 persons served that quarter and SAIOP had the highest number of persons served in the third quarter 2008-09 with 1,638 persons served that quarter.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2009.
*NOTE: Data reported in the fourth quarter of SFY 2008-09 is incomplete due to lag time for claims to be submitted and paid.

The Division is working to define a well-balanced array of services, so that the *distribution* among types of enhanced services offered can be balanced, even if the overall number of best-practice service providers may not grow during the current economic downturn.

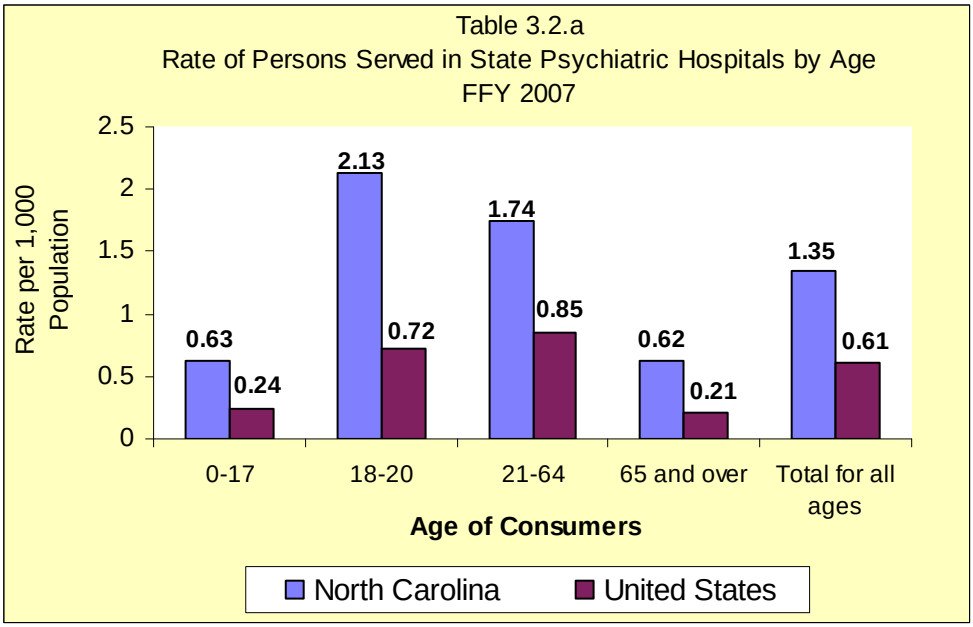
Measure 3.2: Use of State Operated Services

Psychiatric Hospitals: A service system in which individuals receive the services and supports they need in their home communities allows them to stay connected to their loved ones. This is a particularly critical component of recovery or self-determination in times of crisis. As discussed under Measure 3.1 above, service systems that provide community-based crisis response services can help individuals maintain support from their family and friends, while reducing the use of state-operated psychiatric hospitals in times of acute crisis.

As stated in previous reports, North Carolina has used its state psychiatric hospitals to provide both acute (30 days or less) and long-term care. In most other states, acute care is provided in private hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stay.

According to Table 3.2.a on the next page, North Carolina has continued to provide treatment for persons in its state psychiatric hospitals at more than twice the national rate across all ages, according to the most

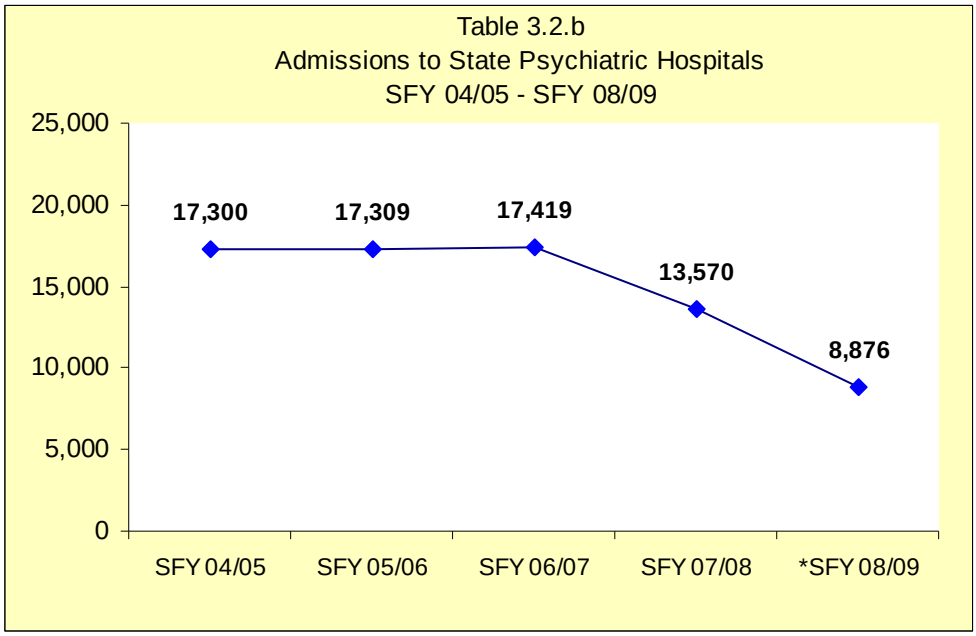
recent report (federal fiscal year (FFY) 2007) from the Center for Mental Health Services (CMHS).



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data as reported in the North Carolina Community Mental Health Block Grant report, FFY 2007.

Over the past five years, the number of admissions to the state psychiatric hospitals has been significantly reduced, as shown in Table 3.2.b on the next page.[6] Since SFY 2004-05, the number of admissions decreased by approximately 50%. However, when state hospitals are continuously operating at full capacity, there is a related decrease in the number of admissions, which partially explains the sharp decrease in admissions in the past two fiscal years.

[6] The numbers for SFY 2008-09 are preliminary. They will be final in November 2009 and updated in future reports.

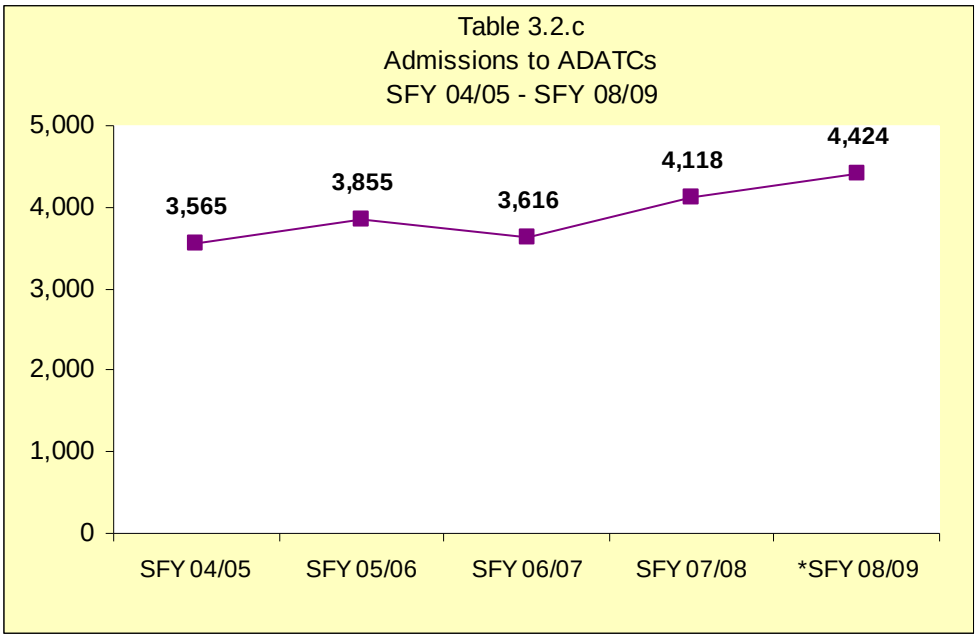


SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for state psychiatric hospital admissions during July 1, 2004 - June 30, 2009.

Since July 1, 2009, 73 new community inpatient beds have been made available in 12 LMEs with funds appropriated by the legislature in 2008. These additional beds allowed for a 24 percent increase in the number of persons served in community hospitals in SFY 2008-09. **The Division expects these new beds, coupled with the community crisis services discussed above, to help relieve the admissions pressure on state psychiatric hospitals.**

Alcohol and Drug Abuse Treatment Centers: In contrast to efforts to *reduce* the use of state psychiatric hospitals for short-term care, the Division continues to work with the new Division of State-Operated Healthcare Facilities (DSOHF) to *increase* the use of state alcohol and drug treatment centers (ADATCs) for acute care. ADATCs are critical resources to serve individuals who are exhibiting primary substance abuse problems that are beyond the treatment capacity of local community services, but for whom psychiatric hospitalization is not appropriate. Due to an increase in acute capacity in the ADATCs and enhanced management practices, total admissions to ADATCs has climbed substantially from 3,565 in SFY 2004-05 to 4,424 in SFY 2008-09 (a 24% increase).[7] With the opening of acute units, the ADATCs are now able to serve individuals with substance abuse problems that are under Involuntary Commitment and then provide step-down inpatient services prior to discharge to ongoing treatment in the community**.** In addition to making needed substance abuse care more available and continuous, this increased capacity helps to relieve the inappropriate use of state psychiatric hospitals for persons with substance abuse disorders. **The Division expects admissions to ADATCs to continue increasing over the current fiscal year.**

[7] The numbers for SFY 2008-09 are preliminary. They will be final in November 2009 and updated in future reports.

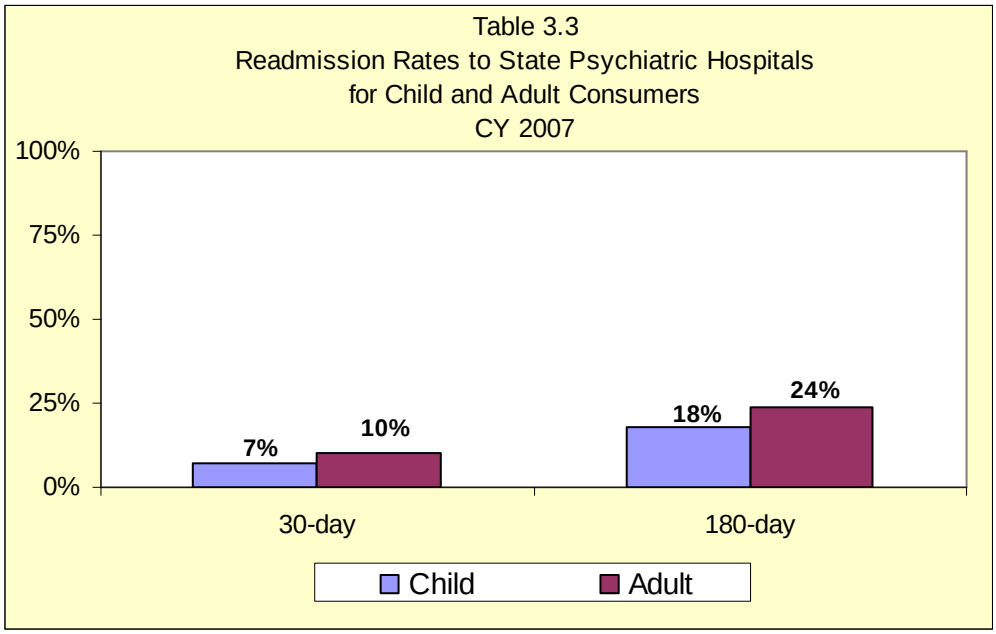


SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for ADATC admissions during July 1, 2004 - June 30, 2009.

Measure 3.3: State Psychiatric Hospital Readmissions

An effective service system provides enough support to help prevent consumer crises and minimize their impact through appropriate planning and treatment. Recurring hospitalization for persons who are likely to experience frequent crises is a signal that additional supports are needed. Tracking hospital readmissions within 30 days of discharge is a nationally-recognized measure of consumer care that provides the Divisions with information on where more comprehensive services might be needed.

Table 3.3, shown on the following page, shows the percent of child and adult consumers requiring readmission to state hospitals within 30 days and within 180 days of discharge. For both child and adult admissions, the readmission rates are more than double when comparing the 30 day and the 180 day follow-up periods. Also, as seen in the table below, state psychiatric hospital readmissions for child consumers are significantly lower than that of adult consumers for both the 30-day and 180-day time periods. **The Divisions expect that expanded access to community crisis services will decrease readmissions to state psychiatric hospitals.**



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for HEARTS Discharges January 1, 2007 - December 31, 2007.

Measure 3.4: Transitions to Community from State Developmental Centers

The Divisions are working to increase opportunities for individuals with developmental disabilities to live in community settings, when appropriate and desired. For individuals moving from the developmental centers to the community, transition planning begins many months prior to discharge.[8] This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center.

During SFY 2008-09, a total of 13 individuals were discharged from the general population of the developmental centers to the community.[9] All thirteen individuals went directly from services at the developmental centers to services in the community. Table 3.4.on the following page, shows the type of community setting to which the individuals moved.

While movement of individuals to community settings has continued slowly, the Divisions expect that the NC-START program will increase opportunities for individuals to move to community settings in SFY 2009-10 by ensuring access to necessary crisis and respite services.

[8] Best practice for persons with developmental disabilities moving from one level of care to another is to receive immediate follow-up care that adheres to prior planning decisions that involved all relevant parties.

[9] This number does not include persons discharged from specialty programs or respite care in the developmental centers.

Table 3.4
Follow-Up Care for DD Consumers Discharged from State Developmental Centers
SFY 2008/09

Time Period	Number of Individuals Moved to Community	Type of Community Setting
July – September 2008	2	2 to supervised living
October – December 2008	4	3 to ICF-MR group home 1 to supervised living
January – March 2009	3	1 to ICF-MR group home 2 to natural family
April – June 2009	4	2 to ICF-MR 2 to supervised living

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system improvement is building a recovery-oriented service system. Recovery and stability for a person with disabilities means having independence and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

All persons – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family, and to participate positively in the larger community. The SAMHSA National Outcome Measures and the CMS Quality Framework include a wide variety of measures of consumers' perceptions of service outcomes and measures of functioning in areas such as:

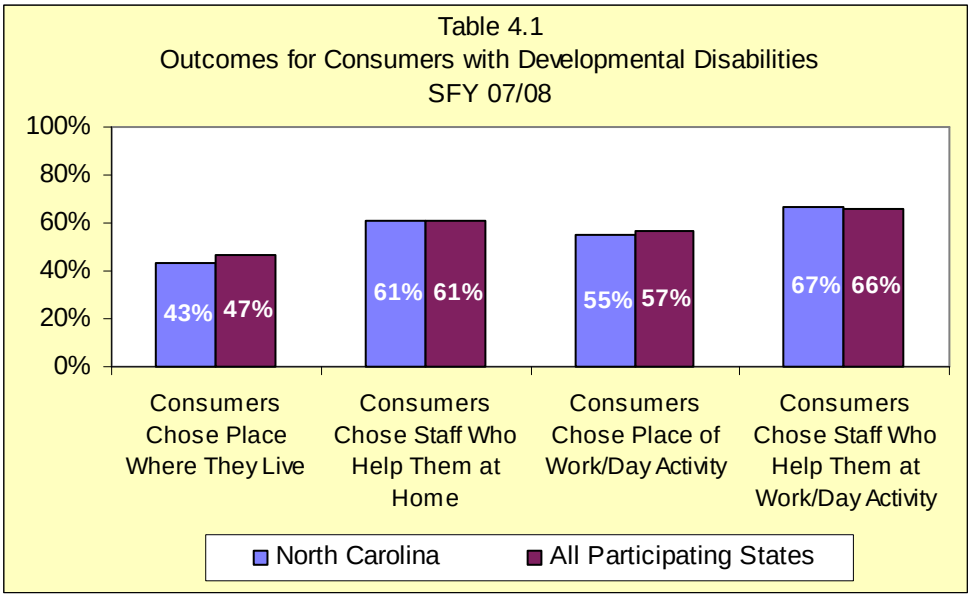
- Symptom reduction, abstinence, and/or behavioral improvements
- Housing stability and independence
- Enhanced employment and education
- Social connectedness
- Reduction in emergency department and hospital inpatient care
- Reduction in criminal involvement
- Participation in self-help and recovery groups

The Division continues working to ensure that individual progress on these consumer outcomes is addressed as a regular part of developing and implementing consumers' person-centered plans. Based on analysis of data on consumer outcomes, the Division adopted improvements in two of these areas – housing and employment / education – as objectives in the *State Strategic Plan 2007-2010*.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

As seen in Table 4.1, in annual interviews with DD consumers in SFY 2007-08, the majority of individuals in North Carolina reported having input into life decisions. (See Appendix D for details on this survey.) Across all four measures related to housing and daily activities, North Carolina was slightly below the average among all states using the survey, but ranked most closely with the measures related to choosing staff to assist individuals at home and at work. While less than half of consumers with developmental disabilities reported choosing where they live, 61% reported choosing the staff that help them in their home. Over half of the consumers in North Carolina reported choosing their place of work or day activity and two-thirds of consumers reported choosing the staff who assist them in their work or day activity.

The Division expects that the state's focus on education and employment opportunities will continue to increase choices for consumers, although this progress may be slowed by the impact of the current economic downturn.



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2007-08.

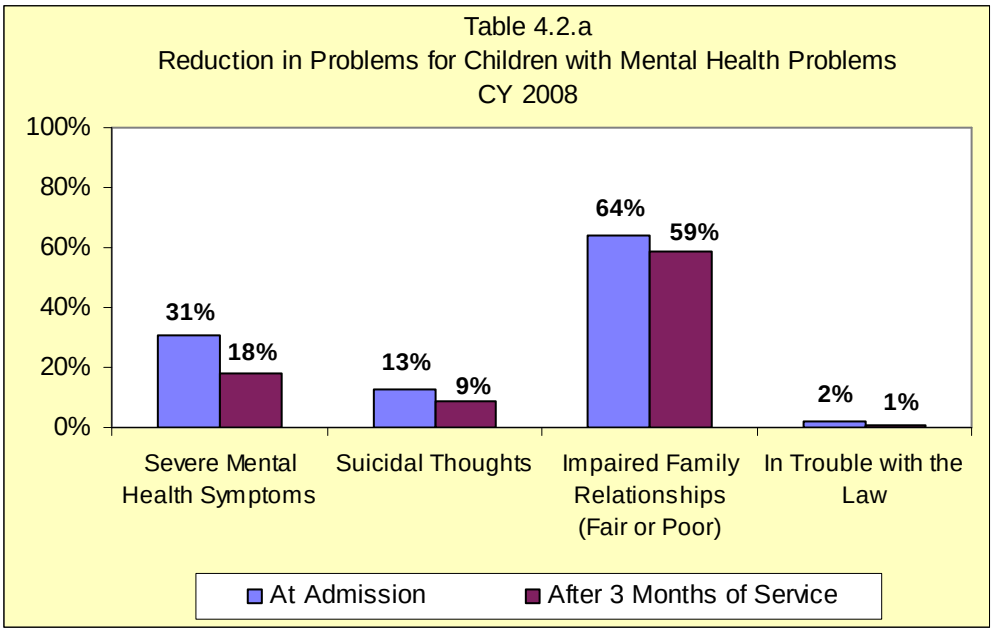
Measure 4.2: Outcomes for Persons with Mental Illness

For persons with mental illness, SAMHSA is focusing National Outcome Measures on reducing symptoms that limit consumers' abilities to maintain positive, stable activities and relationships. Successful engagement in services for even three months can improve consumers' lives, as shown in data from NC-TOPPS consumer interviews below. (See Appendix D for details on the NC-TOPPS system used to collect this data.)

The Division has been recognized nationally for its NC-TOPPS consumer outcomes system that provides excellent evidence of a service system that is impacting the positive well-being of consumers throughout the system. The system is pivotal to the efforts of the Divisions, LMEs and providers to effectively implement and evaluate quality care that is both accountable and cost-effective.

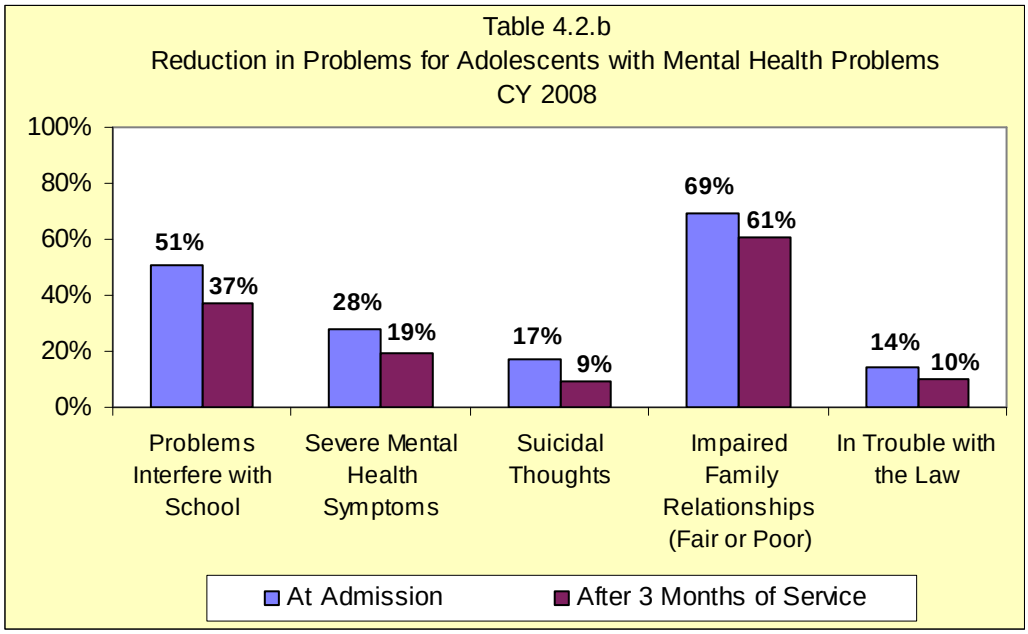
Table 4.2.a on the following page, shows improvement in the lives of children under age 12 with mental health problems (who received at least three months of treatment during Calendar Year 2008) in the following four areas: severe mental health symptoms, suicidal thoughts, impaired family relationships,

and trouble with the law. All of these areas showed improvements after three months of treatment, the most noticeable being a thirteen percentage point drop in severe mental health symptoms. This improvement is extremely important and points to treatment that has made a positive impact in the lives of these consumers.



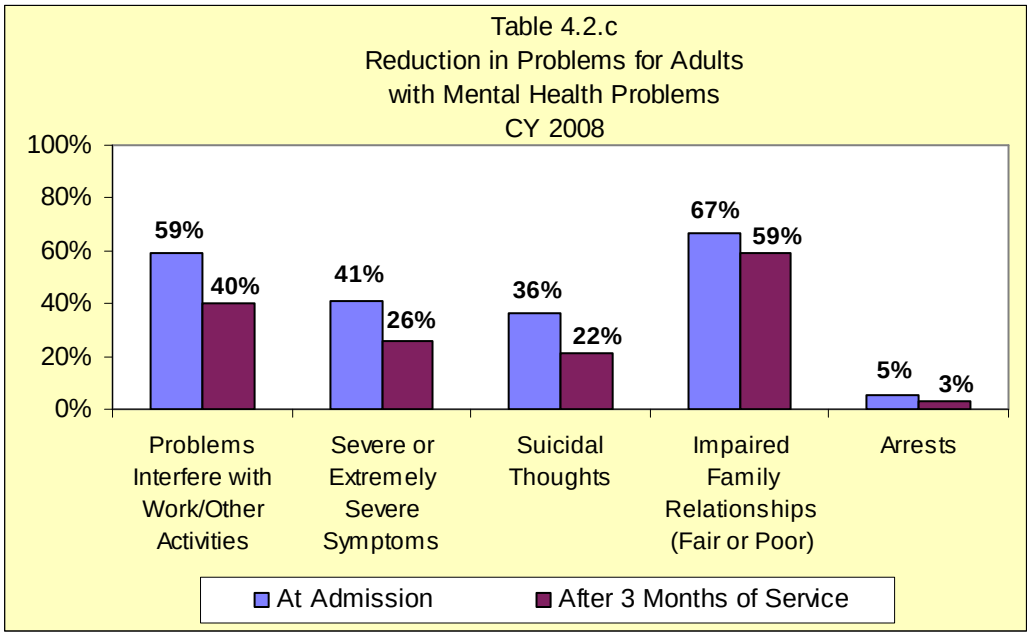
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2008 - December 31, 2008 matched to 3-Month Update Interviews.

Table 4.2.b on the next page, shows improvement in the lives of adolescents (ages 12 to 17) with mental health problems (who received at least three months of treatment during Calendar Year 2008) in the following areas: problems in school, severe mental health symptoms, suicidal thoughts, impaired family relationships, and trouble with the law. The rate of suicidal thoughts was almost cut in half between at the time of admission to after three months of treatment (from 17% to 9%, respectively). The most improvement is seen in a substantial fourteen percentage point decrease in adolescents having problems that interfere with school. The importance of this improvement cannot be over-emphasized in promoting the wellbeing and enhanced functionality of youth in this critical life domain.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2008 - December 31, 2008 matched to 3-Month Update Interviews.

As seen in Table 4.2.c on the next page, progress was made in the lives of adults with mental health problems in reducing their symptoms and the problems associated with those symptoms after only three months of treatment. Similarly to adolescents, the greatest gain was in reduction of problems with work or other activities (down 19 percentage points). Other noteworthy gains were made in reducing the severity of mental health symptoms (down 15 percentage points) and suicidal thoughts (down 14 percentage points). In addition, some improvements were made in family relationships as well as reducing arrests during treatment. Collectively, these findings are very meaningful in portraying the effectiveness of treatment of adults with mental health problems.

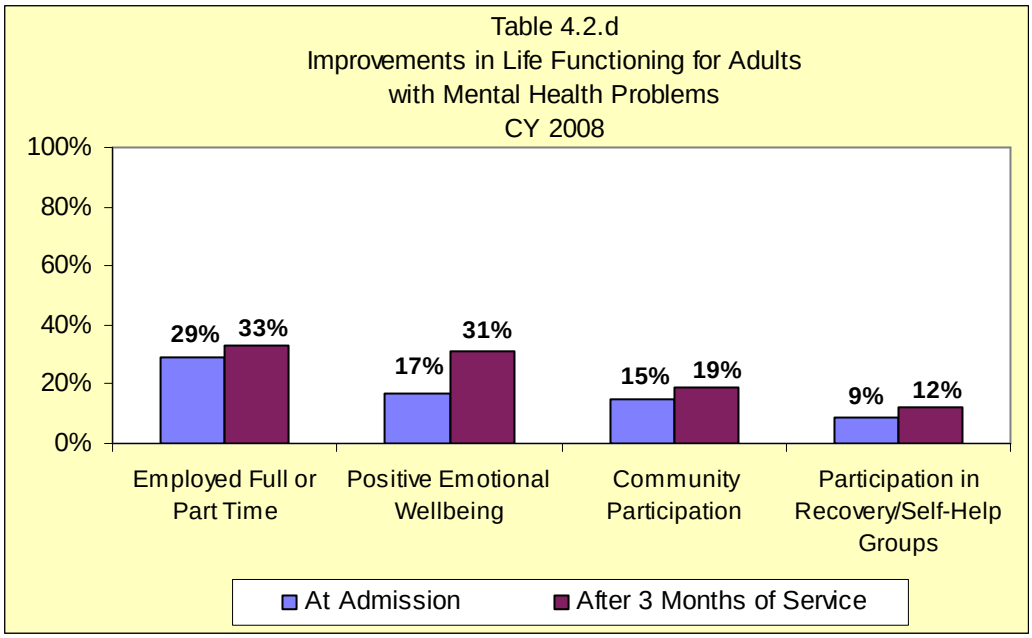


SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2008 - December 31, 2008 matched to 3-Month Update Interviews.

Three months of service also made a positive difference in the quality of life for adults with mental health problems as seen in Table 4.2.d on the next page.

- The percent of adults employed full or part-time increased slightly.
- The greatest gain was made in the percent of adults reporting positive emotional wellbeing (increase of 14 percentage points).
- The percent of adults participating in positive community activities and recovery or self-help groups increased slightly.

These gains all point to significant strides of adults in in treatment to achieve goals of increased security, stability and integration in the community.



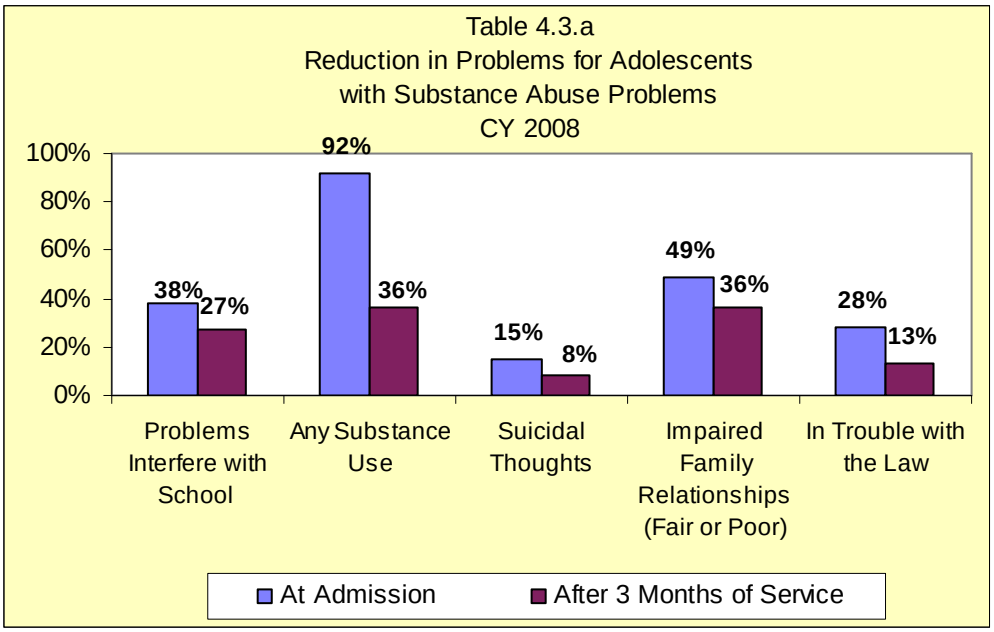
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2008 - December 31, 2008 matched to 3-Month Update Interviews.

Adults and children who remain engaged in services for more than three months can be expected to continue improving in all of the areas shown above. **With continuous services based on person-centered goals, the Division expects to see long lasting improvements in these areas.**

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

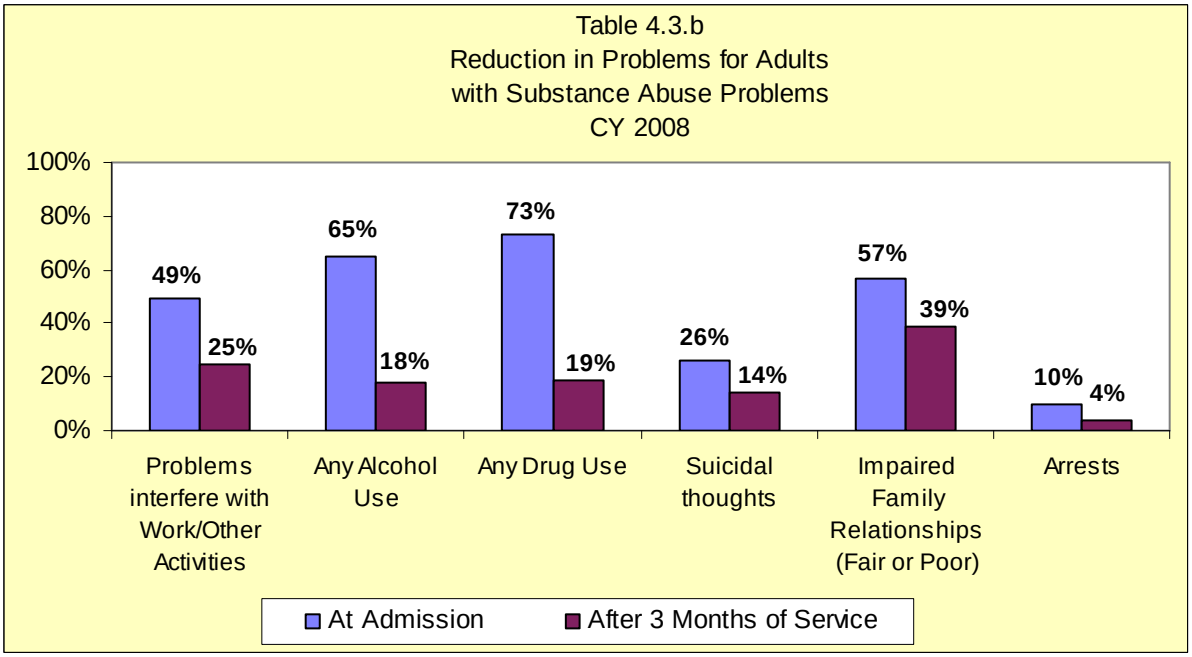
SAMHSA National Outcome Measures for persons with substance abuse problems focus on eliminating the use of alcohol and other drugs in order to improve consumers' well-being, social relationships and activities. Successful initiation and engagement in services with this population can have very positive results in a short time, as shown in the data from NC-TOPPS consumer interviews below. (See Appendix D for details on the NC-TOPPS system used to collect this data.) The NC-TOPPS consumer outcomes system is also responsible for the collection, reporting, and utilization of vital outcomes for substance abuse consumers that ensure accessible, efficient, and effective treatment services.

Table 4.3.a on the next page, shows that the lives of adolescents (ages 12 to 17) with substance abuse problems who received three months of treatment during CY 2008 improved meaningfully in a variety of areas. Most notably, the percent of youth who used substances decreased drastically and those in trouble with the law dropped by more than half. In addition, youth with impaired family relationships decreased by 13 percentage points and problems interfering with school saw a decrease of eleven percentage points. The importance of these critical gains cannot be overemphasized in portraying the effectiveness of treatment services in dramatically decreasing consumer problems across a variety of critical life domains.



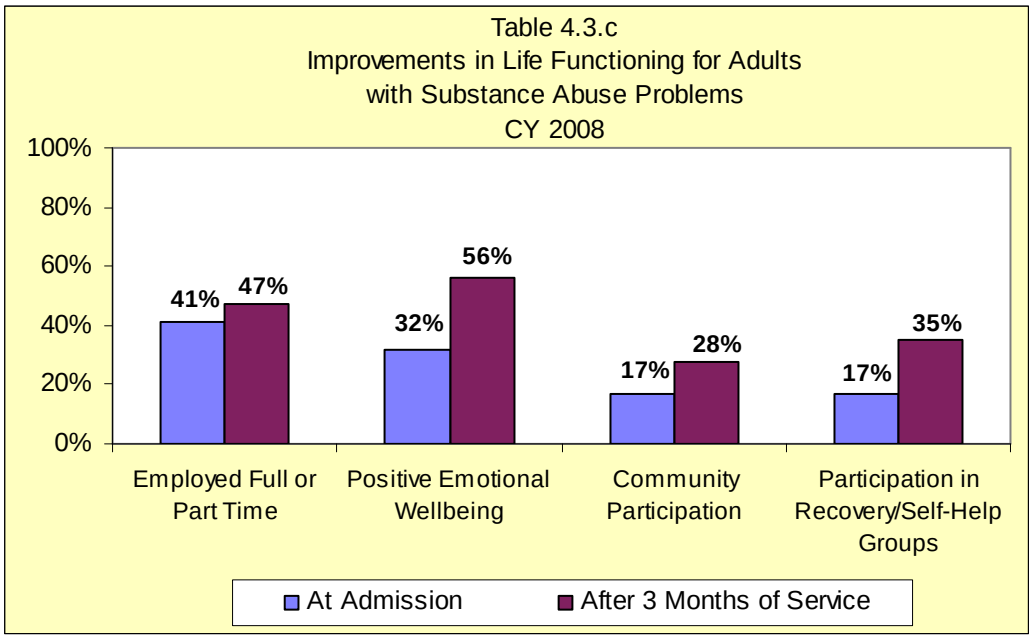
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2008 - December 31, 2008 matched to 3-Month Update Interviews.

Similar progress was made among adults in reducing substance use and related problems as shown in Table 4.3.b on the next page. The most notable decreases can be seen in the percent of adult consumers using drugs or alcohol. The decrease in the use of drugs among adult consumers was a solid 54 percentage points and the decrease in the use of alcohol was a noteworthy 47 percentage points. In addition, the percent of adults that had problems interfere with their daily activities or had suicidal thoughts was roughly cut in half while the percent of adults arrested decreased by more than half. .



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2008 - December 31, 2008 matched to 3-Month Update Interviews.

Table 4.3.c shows that services also had a positive impact on the quality of life of adult substance abuse consumers. The percent of adults employed full or part-time increased by six percentage points while the percent of adults reporting positive emotional wellbeing increased from roughly a third at admission to more than half after three months of service. In addition, the percent of adults participating in positive community activities increased by eleven percentage points and the percent of adults participating in recovery or self-help groups more than doubled..



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2008 - December 31, 2008 matched to 3-Month Update Interviews.

As seen for adult mental health consumers, helping adult substance abuse consumers maintain and improve their employment situation is an area with room for improvement. **The Division expects those who remain engaged in services for more than three months to continue improving in this and other areas of their lives.**

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.
- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.

- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

Measure 5.1: Assurance of Basic Service Quality

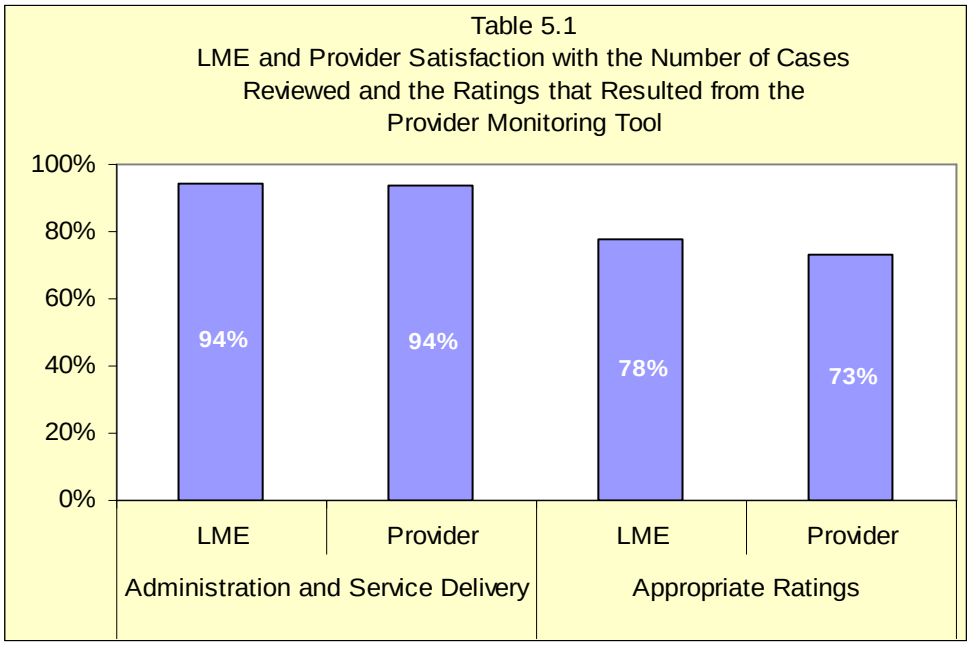
In January 2009 the Division implemented the Provider Monitoring Tool to assist LMEs in oversight of community-based providers of Medicaid-funded and State-funded services. The Provider Monitoring Tool is used by LMEs to (1) assess provider performance in an efficient manner and (2) identify areas requiring more follow-up or in-depth inquiry. The companion *Guide to Standardized Administration of the DMH/DD/SAS Provider Monitoring Tool for Local Management Entities* was developed to assist in training LME staff to use the tool for local monitoring in a consistent manner across the state.

The tool is designed to identify areas of performance that are critical in assuring compliance with quality standards in the provision of services to consumers. These areas include quality management; staff competencies and experience; person-centered planning, services and supports; protection of individual rights; and protection from harm (provider response to incidents and complaints). The monitoring tool enables LMEs to identify red flags or triggers to direct staff resources where they are most needed for more in-depth or targeted monitoring. The tool does not cover every DMH/DD/SAS requirement; rather, it helps LMEs to assess a provider's performance in key areas across all its services.

A survey was developed for both LMEs and provider agencies to submit upon completion of the monitoring process in order to assess the quality of the items included in the Provider Monitoring Tool. The results of the survey are being used to make adjustments to the monitoring process and components of the monitoring tool.

Table 5.1 shows the results of 71 surveys completed by LMEs and 68 surveys completed by provider agencies through July 2009. The overwhelming majority of LMEs and providers (94%) stated the number of cases reviewed was sufficient for making a determination of the quality of administration and service delivery within the agency. Slightly more LMEs (78%) compared to providers (73%) stated that the actions required as follow-up for the different ratings were appropriate to the level of need indicated by the ratings.

The Division expects the continued use of the Provider Monitoring Tool as part of the LMEs' local monitoring activities to improve the quality of community-based services, by clarifying and standardizing the State's expectations for quality services and by identifying providers in need of technical assistance to meet those expectations.



SOURCE: Provider Monitoring Survey; LMEs and provider agencies, January - August 2009.
http://www.ncdhhs.gov/mhddsas/provider_monitor_tool/index.htm

Measure 5.2: North Carolina Incident Response Information System (NC-IRIS)

Community service providers report over 14,000 incidents each year, ranging from missed medications and consumer injuries to consumer deaths. Ensuring appropriate response to such incidents and improvements to minimize the occurrence of future incidents requires managing an enormous amount of information. NC-IRIS is a web-based incident reporting system that is replacing the current paper-based DHHS Incident and Death Reporting process. All community-based MH/DD/SAS provider agencies will transition to the new system between October 2009 and March 2010. (See screen shots of NC-IRIS displayed on the following pages.)

Highlights of NC-IRIS:

- **NC-IRIS will do away with the paper system**, saving provider staff time and thousands of pieces of paper. In the paper system, incident reports have been completed by the provider and faxed, mailed or hand-delivered to multiple agencies, including one or more LMEs and multiple state agencies. Incidents involving the use of restrictive interventions or accusations of staff abuse of consumers require submission of additional forms.

- **NC-IRIS will automatically notify all local and state government staff with oversight responsibilities,** including the provider's LME, the consumer's home LME (if different), the Division's quality management and clinical oversight staff, the Division of State-Operated Healthcare Facilities staff, the Division of Health Service Regulation (DHSR) Complaint Intake Unit, the DHSR Health Care Personnel Registry (HCPR), and the DHSR Construction Unit (facility fires).

- **NC-IRIS will accept supplemental documents**, such as Medical Examiner Reports, Autopsy Reports and Toxicology Reports, which can be scanned into the system. NC-IRIS will notify the appropriate users when these are submitted.

- **Incident report entry is user-friendly**. Data entry involves completion of a series of questions with check and drop-down boxes that minimize entry time, while providing standardized data that can be used for tracking trends and patterns. The system guides the user to the sections they need to complete, skipping over those unrelated to the type of incident being reported.

- **NC-IRIS generates real-time data reports** to local and state government staff responsible for oversight and incident management. These reports will provide LME and DHHS staff with up-to-date information that can be used to identify patterns of concern and success to guide training and technical assistance for providers, as well as statewide initiatives to improve the safety and health of DHHS consumers.

In summary, this system provides the basis for an enormous leap forward in coordination, oversight, and accountability towards improving care throughout the state system.

Domain 6: System Efficiency and Effectiveness

System Efficiency and Effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and thorough information management.

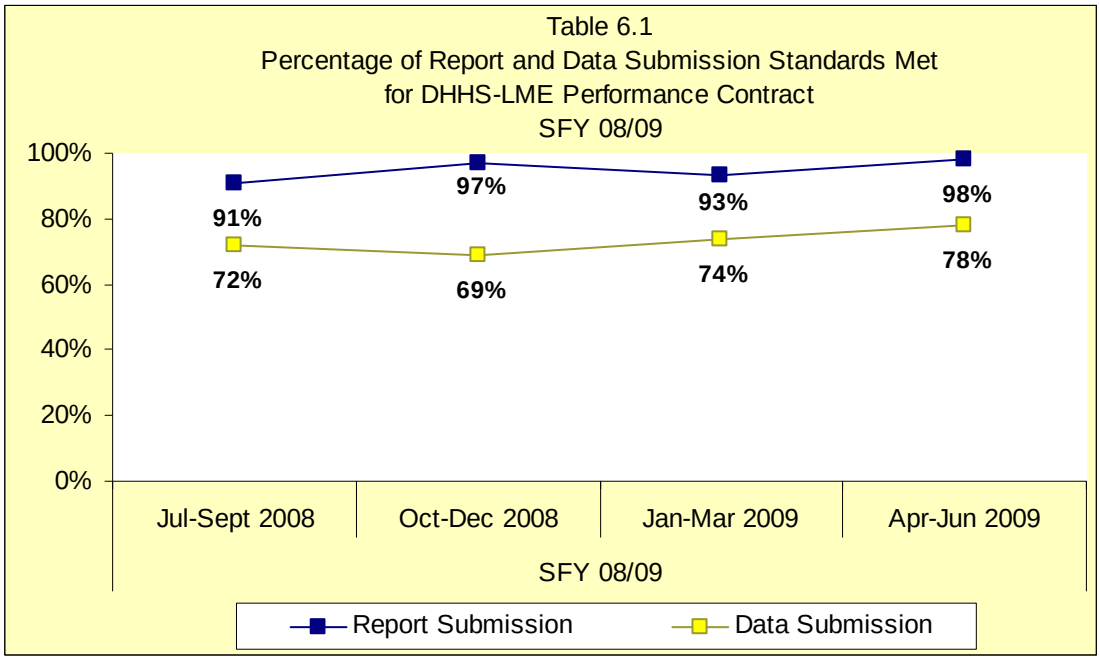
Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. It includes a standardized scope of work detailing the components of each function that the LMEs are expected to perform, reporting expectations, and critical system performance indicators.

Measure 6.1: Business and Information Management

Consumer data reported by the LMEs is coupled with claims data to generate the information that the Division uses to evaluate local and state system performance and to keep the Legislature informed of system progress through this report. For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely, complete and accurate submission of consumer and program information. The LMEs' compliance with reporting requirements provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

As shown in Table 6.1, LMEs' submission of timely and accurate information to the Division has fluctuated during SFY 2008-09. In all quarters, LMEs' have consistently performed better with meeting the report submission requirements than meeting the data submission requirements. Submissions of both types of information have improved in the last quarter of SFY 2008-09. Report submissions rose seven percentage points over the course of the fiscal year. Data submissions rose six percentage points. These are meaningful improvements but also point to the need for continued attention.



SOURCE: Data from SFY 2008-09 Quarterly Performance Contract reports.

Since much of the LMEs' data on consumers now comes from private providers, increased coordination and communication between LMEs and providers is necessary to ensure the timely flow of information. The Department provides information to LMEs on Medicaid-funded consumers to help ensure timely notification about individuals served in the catchment area. The LMEs, in turn, use this information to monitor the provision of consumer services and providers' compliance with data reporting requirements.

Due to budget cuts for SFY 2009-10, the Division is seeking ways to streamline or reduce reporting requirements without compromising the LMEs' and Department's capacity to use data to manage the service system.

Measure 6.2: Efficient Management of Service Funds

In SFY 2008-09 thirteen out of the twenty-four LMEs received single-stream funding, which provides them with service fund allocations prior to service delivery. Instead of submitting claims to IPRS for reimbursement of services that have been delivered, these LMEs are required to report consumer and service-specific information, called "shadow claims," to IPRS after delivery of those services. Although single-stream funding removes the financial incentive for reporting claims, the *DHHS-LME Performance Contract* requires LMEs with single-stream funding to report at least 85% of the value of their service allocations through shadow claims.

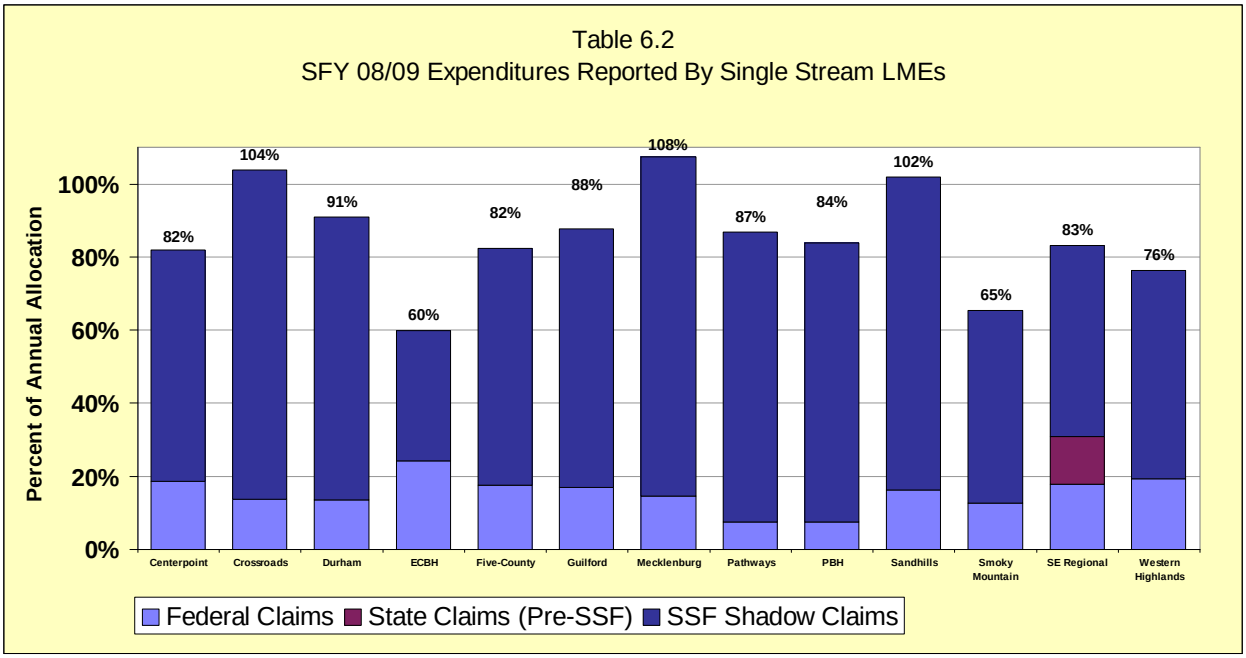
As indicated in Table 6.2, six LMEs have reported more than the expected volume of services for the fiscal year as shadow claims, with three actually exceeding the expected 100% of expenditures reported.[10] Four additional LMEs reported over 80% of their annual funding allocations. The Division has identified

[10] The Single Stream funds reported here includes state and federal allocations; it excludes LME system management funds and Medicaid claims processing fees paid by the Division. LMEs may also report county-funded services.

three LMEs – East Carolina Behavioral Health, Smoky Mountain, and Western Highlands Network –that are in need of improvement in this area.[11]

Two additional LMEs (Eastpointe and Mental Health Partners) started single-stream funding in July 2009. The Division will continue working with all single-stream LMEs to reinforce the importance of reporting shadow claims. **The Division expects single-stream LMEs to continue improving their reporting of shadow claims, as expectations continue to be reinforced.**

Table 6.2
SFY 08/09 Expenditures Reported By Single Stream LMEs



SOURCE: Integrated Payment and Reporting System Service Data (for shadow claims submitted by Single-Stream Funded LMEs, July 1, 2007 – June 30, 2008)

Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public, specific groups known to be at risk, and individuals who are experiencing early signs of an emerging condition. Prevention education focuses on the nature of mental health, developmental disability, and substance abuse problems and how to prevent, recognize and address them appropriately. **Early intervention** activities are used to halt the progression or significantly reduce the severity and duration of an emerging condition.

Measure 7.1: Substance Abuse Data Inventory, North Carolina State Epidemiological Work Group

As discussed in the Fall 2008 issue of this report, North Carolina is one of the recipients of the Strategic Prevention Framework State Incentive Grant (SPF-SIG), a state-federal cooperative agreement funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance

[11] Southeastern Regional LME began receiving single-stream funding in October 2008.

Abuse Prevention (CSAP). The three phases of the project include a statewide needs assessment, an in-depth local needs assessment, and development and implementation of strategies to address local needs. As part of the second phase, technical assistance is being provided to the local communities. The State Epidemiological Work Group, an arm of the SPF-SIG, has produced a comprehensive resource for communities focusing on substance abuse consumption and consequences called the ***Substance Abuse Data Inventory, 2009***. The report provides descriptions and tables for data repositories, data systems, and data sources where indicators of substance abuse patterns in North Carolina can be found. It serves as a quick reference guide on substance abuse data for community planners and evaluators. The ***Data Inventory*** is published on the Division's Statistics and Publications webpage at http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

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Appendix A: Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

> "The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals…."

In addition, NC G.S. 122C-102(c) was revised to read:

"The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on the State's progress in these performance areas."

Appendix B: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

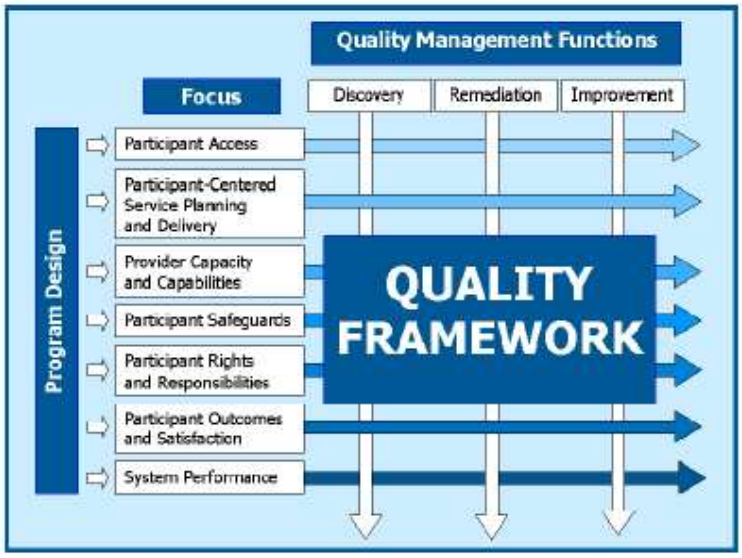
DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		Under Development	Total number of evidence-based programs and strategies

[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.

Appendix C: CMS Quality Framework

HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered **desired outcomes** along seven dimensions.



Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

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Appendix D: Description of Data Sources

Domain 1: Access to Services

Tables 1.1.a – 1.1.c Persons Served: The Division Client Data Warehouse (CDW) provides data on persons served. This system is the primary repository for data on persons receiving public mental health, developmental disabilities, and substance abuse services. It contains consumer demographic and diagnostic information from extracts of the LMEs' management information systems and DHHS service reimbursement systems. It also contains information on consumers' use of state-operated facilities and consumer outcomes extracted from the HEARTS and NC-TOPPS systems described below.

The number of persons served (unduplicated) is calculated by adding the active caseload at the beginning of the fiscal year (July 1) and all admissions during the fiscal year (July 1 through June 30) and subtracting discharges during the fiscal year. The disability of the consumer is based on the diagnosis reported for the consumer on paid IPRS and/or Medicaid service claims. The consumer's age on June 30 at the end of the fiscal year is used to assign the consumer to the appropriate age group (e.g. children or adults).

Table 1.2 Persons Seen within Fourteen Days of Request: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the next 14 days and multiplying the result by 100. The information comes from data submitted by LMEs and published in the *Community Systems Progress Reports*. The sources are LME screening, triage, and referral logs and quarterly reports submitted by the LMEs. The data reflect consumers who requested services from an LME. It does not include data on consumers that directly contacted a provider for an appointment. The Division verifies the accuracy of the information through annual on-site sampling of records. More information on the *Community Systems Progress Report* can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Domain 2: Individualized Planning and Supports

Tables 2.1.a and 2.2.a Choice among Persons with Developmental Disabilities: The data presented in these tables are from mail surveys with North Carolina families of consumers with developmental disabilities in the project year 2007-08, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities via in-person interviews and their parents and guardians via mail surveys. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: http://www.hsri.org/nci/index.asp?id=reports.

Tables 2.1.b and 2.2.b Choice among Persons with Mental Health and Substance Abuse Disabilities: The SAMHSA-sponsored Mental Health Statistical Improvement Project's Consumer Survey (MHSIP-CS) provides this data. Each LME surveys five percent of its active consumers in the fall of each year. This confidential survey asks questions about the individual's access to services, appropriateness of services, service outcomes, and satisfaction with services. More information on the MHSIP-CS can be found at: http://www.mhsip.org/. Annual reports on North Carolina's survey can be accessed at: http://www.ncdmh.net/dsis/LMEdirectory.html.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.c Persons Receiving Evidence-Based and Best Practices: Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

Tables 3.2.a and 3.2.b Management of State Hospital Usage: The data on the rate of persons served in state psychiatric hospitals by age groups of consumers comes from the North Carolina Community Mental Health Services Block Grant report, which is based on data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated facilities. The data on state hospital admissions in SFY 2004-05 through SFY 2008-09 comes from data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated healthcare facilities. The Division also reports this information in the North Carolina Psychiatric Hospital Annual Statistical Report, which is published by the Division and based on data in HEARTS. This report can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Table 3.2.c Admissions to ADATC Facilities: The data on admissions to ADATCs in SFY 2004-05 through SFY 2008-09 come from data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated facilities. The Division also reports this information in the North Carolina ADATC Annual Statistical Report. This report can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Tables 3.3.a and 3.3.b State Psychiatric Hospital Readmission: The data on state hospital readmissions (30 days and 180 days after discharge) in CY 2008 come from data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated healthcare facilities.

Table 3.4 Follow-up Care for Consumers Discharged from State Developmental Centers: These data are for SFY 2008-09 and come from reports submitted quarterly by the developmental centers to the Division of State Operated Healthcare Facilities. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Domain 4: Consumer Outcomes

Table 4.1 Outcomes for Persons with Developmental Disabilities: This information is obtained through in-person interviews with consumers as part of the NCIP, described in Tables 2.1.a and 2.2.a above.

Tables 4.2.a - 4.3.c Service Outcomes for Individuals with Mental Health and Substance Abuse Disabilities: This information comes from the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule through clinician-to-consumer interviews for all persons ages 6 and over who receive specific mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://www.ncdhhs.gov/mhddsas/nc-topps.

Domain 5: Quality Management

Tables 5.1 - 5.2 Quality Improvement Activities: A Provider Monitoring Survey was developed for LMEs and provider agencies that are currently involved in the monitoring process using the Provider Monitoring Tool. The results from the survey provide the developers of the Provider Monitoring Tool the

feedback necessary to make any adjustments to the monitoring process or components of the monitoring tool.

NC IRIS is a web-based incident reporting system that will be implemented in October 2009 and will replace the current DHHS Incident and Death Reporting System.

Domain 6: Efficiency and Effectiveness

Table 6.1 Business and Information Management: Table 6.1 includes timely, complete and accurate submission of information required in the *DHHS-LME Performance Contract* over the last state fiscal year. This report tracks LME performance in submitting required data and reports to the Division. Some requirements are quarterly while others are semi-annual or annual requirements. For these reasons, the number of requirements included in the denominators for Table 6.1 fluctuates over the four fiscal quarters represented. More information on the *DHHS-LME Performance Contract*, including the quarterly reports, can be found at: http://www.ncdhhs.gov/mhddsas/performanceagreement/.

Table 6.2 Percent of Funds Spent: The data for Table 6.2 on shadow claim submissions come from service claims submitted to the IPRS by LMEs with single-stream funding between July 1, 2008 and June 30, 2009. Submitted claims that are reimbursed with federal funds on a unit-cost basis or denied due to lack of funds (a fiscal denial) are included in the numerator, along with federal funds paid on an expense basis. The denominator includes total annual allocations, excluding funds for LME system management and funds received from the Mental Health Trust Fund.

Domain 7: Prevention and Early Intervention

Measure 7.1 North Carolina Strategic Prevention Framework State Incentive Grant: The Substance Abuse Data Inventory can be found on the Division's website at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/substanceabusedatainventory4-7-09.pdf. Additional information on the North Carolina Strategic Prevention Framework State Incentive Grant, including the *State Epidemiological Profile* and the *North Carolina SPF SIG Strategic Plan* can be found at: www.ncspfsig.org.